Debate on the Legalisation of Cannabis for Medical Use in the United Kingdom

The debate over the legalisation of cannabis for medical use in the United Kingdom: assessing the evidence base to examine ethical and legal issues in meeting patient's needs.

Cannabis is the single most commonly abused, trafficked and cultivated illicit drug globally (Bridgeman and Abazia, 2017), with the World Health Organization (WHO, 2016) reporting marijuana is consumed by 2.5% of the population globally each year. Cannabis use in the United Kingdom (UK) however is illegal, for both medicinal and recreational purposes (Flynn, 2018), as it not legally recognised as having any beneficial value and therefore possession and use is a criminal offence. However, for medicinal use, individuals with certain medical conditions can be prescribed 'Sativex', a cannabis-based product (Nutt, 2018). The Home office in 2006 (HM GOV, 2013) licensed Sativex to be privately prescribed, but at the prescribing doctor's own risk, although this subjective decision-making can be regarded as unethical, in fostering care inequalities in Sativex prescription across the UK (Flynn, 2018). There have been many calls for cannabis to be legalised in the UK, based on evidence of its medicinal benefits (Flynn, 2018; Nutt, 2018). The case of six-year-old Alfie Dingley, who lives with the condition PCDH19, also highlights the potential for cannabis to enhance patients' quality of life, in aiding the management of symptoms such as severe seizures and pain (Busby, 2008). However, UK law prevented Alfie from gaining access to cannabis oil and as Caroline Lucas, (cited in Busby, 2008: 1) states "*There are many, many cases like Alfie's – which see people suffering needlessly because of policies which ignore the scientific evidence [around] medicinal cannabis*,". This essay explores the debates and scientific evidence that supports and refutes the medicinal benefits of cannabis for improving patients' quality of life, whilst examining the potential ethical and legal issues this raises.

Across 29 states of the Unites States (US), and many EU countries, such as Italy, Germany, Portugal, Spain, and the Netherlands, cannabis on prescription is legal (Flynn, 2018). Despite present law in the UK criminalising Cannabis use, a poll reported that 78 percent of UK people believe that cannabis should be legalised for medicinal purposes (Busby, 2008). Cannabis as a medicine has not always been illegal in the UK, as it was prescribed up until 1971, but with growing political pressure from the US, it was banned; on the basis that prohibiting the drug would in turn reduce criminal trafficking of cannabis (Flynn, 2018; Nutt, 2018). However, ironically, most of the US and parts of Europe have now reinstated the medical use of cannabis (Flynn, 2018).

Cannabis contains psychoactive compounds named cannabinoids, such as delta-9-tetrahydrocannabinol [THC] (Dos Santos et al. 2017). THC when smoked, eaten or

absorbed into the skin, triggers responses in the brain within minutes, which can alter physiological and psychological states as well as distorting the perception of factors such as pain (Cohen, and Weinstein, 2018; Dos Santos et al. 2017). However, whilst the effects can be pleasurable, THC is absorbed within fats, making it difficult for the body to discharge – leading to just one dose of cannabis remaining in the body for as long as one month (Scheidweiler et al. 2017). Therefore, a common concern has been that cannabis can build up within the body, causing long-term negative effects doses, combined with the risk of addiction and toxicity (dos Santos et al. 2017).

A retrospective study (Esther et al. 2014) collating 20 years of data from across the US reported that across all states with or without medical Cannabis laws in place; young Cannabis smokers were equally shown to have symptoms of negative effects within their brains. The study employing statistical analysis, a method aligned with the quantitative approach (Caldwell, Henshaw and Taylor, 2011), evidenced a direct correlation, between how much Cannabis was smoked and detrimental brain changes; particularly in relation to emotions and motivation. Further to this, a French study also reported a number of physical health issues associated with cannabis use, with cardiovascular-related complications and even death correlated with cannabis use in young as well as middle-aged adults (Baron, 2015). However, the quality of evidence is poor as retrospective data is notoriously prone to missing data, which makes the findings unreliable (Parahoo, 2014). However, interestingly, Esther et al.'s (2014) study revealed no evidence to suggest legalising cannabis would increase the prevalence rate of its use, as rates were similar across states where Cannabis was both legal and illegal. This indicates that changing the laws in the UK may likely not increase Cannabis use in recreational drug use, which has been the case for it remaining illegal (Flynn, 2018).

In terms of the reported benefits associated with medicinal cannabis, the literature base indicates that medicinal marijuana and the compound of cannabinoids (THC), demonstrate therapeutic benefits across many areas (Baron, 2015). These include; controlling epilepsy (Hill et al. 2012) chronic pain (Aggarwal, 2013), headaches (Baron, 2015), multiple sclerosis (Clifford, 1983), Parkinson's disease (Curtis et al. 2009), and many more conditions (Pertwee, 2012). However, it must also be acknowledged that many studies, demonstrate methodological limitations in the reliability of the methods used, due to being reliant on case notes, anecdotal, and laboratory-based scientific research, which lacks face validity (Baron, 2015; Parahoo, 2014).

However, there are very similar data findings for the efficacy of medicinal Cannabis in chronic pain treatment in suppressing hyperalgesia and allodynia, through the use of THC and synthetic cannabinoids (Kraft, 2012; Karst, Wippermann, and Ahrens, 2010), which somewhat overcomes the weakness in individual studies' reliability. The opioid-

sparing effect, triggered by the cannabinoid–opioid interaction in medicinal marijuana use has been shown to offer a potential alternative to the use of opioid narcotics, which are notoriously linked to dependency, addiction and abuse issues (Baron, 2015). Baron (2015), conducting a review of the history and research surrounding medical cannabis use, questioned whether medical cannabis can also offer a clinical intervention in weaning patients off such opiates; although this requires empirical research to inform this. Initial findings however, revealed that cannabis possesses similar analgesic properties (Raichlen, et al. 2012), with, a 15-20 mg dose of Delta-9 THC being directly comparable to codeine's analgesic effects [60-120 mg] (Baron, 2015). Thus, indicating the beneficial therapeutic effects and applications of cannabis in clinical practice for chronic pain disorders (Baron, 2015). Further to this, a review of 38 Randomised Controlled Trials [RCTs] (Aggarwal, 2013) that assessed the efficacy of cannabinoids in clinical pain management reported that 71% of all included patients experienced significant pain-reduction, evidencing the role that cannabinoids could play in clinical care. However, it must be noted the sample sizes were small for a RCT and as such the study lacks statistical power, rendering the findings unreliable (Robson and McCartan, 2016).

The evidence base demonstrates the potential benefits of cannabis in reducing pain across many chronic conditions, and thus the potential to enhance the quality of life of people living with long-term and chronic conditions. However, the evidence base is limited by methodological issues, such as small samples and use of retrospective data which impedes the quality and therefore reliability of the findings (Parahoo, 2014). Flynn (2018) however, notes that regardless of the reliability of the evidence, the legalisation of medicinal Cannabis should be a moral and ethical concern as opposed to a legal issue. As UK health care strives to foster patient choice and self-management of patients' health care experiences (Department of Health, 2013), Flynn (2018) asserts that legalising cannabis in the UK can facilitate individuals' autonomy and choice, in managing and controlling their own health conditions. Flynn (2018) reports of a police officer's account of living with MS, whose career was bound by a duty to uphold the law, but through ill-health now breaches the law to buy cannabis to cope with the symptoms of the condition. Flynn (2018) describes how, to a certain extent, the law has no real relevance to people's lives, as the police woman describes how both police and prosecutors actively turn a blind eye to such offences; rendering the law in itself inept.

According to Coggon (2012), health care policy, practice and law, each offer contradictory views of what 'health' is, and who and how it should be understood and addressed. Coggon (2012) asserts that health is both individually determined and state-imposed, leading to differences of opinion in determining who knows what is best for the people. In the case of legalisation of medicinal cannabis in the UK, it is the state that

is assuming to know what is best for the population, by legally safeguarding people from the negative effects of cannabis, despite scientific evidence that it may be beneficial (Baron, 2015). According to Tsakyrakis (2009) and in line with health care law, such as the Care Act (2014), patient's views and preferences should be considered when developing care plans, and thus there is a real need to balance the interests and needs of the individual with that of the State. By including patients in such decisions, they will be able to consider the potential risks and benefits associated with medicinal Cannabis, as well as its potential use in managing their chronic and long term ill-health (Flynn, 2018; Beauchamp and Childress, 2001).

In conclusion, whilst there is empirical evidence demonstrating the medicinal benefits, particularly in pain management, of medicinal Cannabis, there is also evidence of the potential side effects, such as risk of toxicity and addiction. However, throughout the world there is inconsistency in the application of law to legalise medicinal Cannabis, and this is fostering health inequalities for people living with chronic conditions. Therefore, as Tsakyrakis (2009) states, in line with ethical and person-centred health care, law in the UK must, in line with other European countries, enable individuals diagnosed with chronic and long-term conditions, the autonomy to choose whether or not to use medicinal cannabis, to enhance their quality of life.